BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
Paula N. Adesokan, M.D.	)	MBC File # 800-2018-041023
	)	
	)	
Physician's & Surgeon's Certificate No. G 88987	)	
	)	
	)	
Respondent.	)	

ORDER CORRECTING NUNC PRO TUNC
EFFECTIVE DATE ERROR ON PAGE 5 OF DECISION

On its own motion, the Medical Board of California (hereafter "board") finds that there is a clerical error in the effective date of the Decision on page 5 in the above-entitled matter.

IT IS HEREBY ORDERED that the effective date on page 5 in the Default Decision and Order be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as "November 8, 2018". This order replaces the previous order signed by Ronald H. Lewis, M.D., Chair, Panel A, as Default Decisions are adopted by the Executive Director.

Dated: October 15, 2018

Kimberly Kirchmeyer
Executive Director

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Paula N. Adesokan, M.D.	)	**Case No. 800-2018-041023**
Physician's and Surgeon's Certificate No. G 88987	)	
Respondent	)	

DECISION

The attached Default Decision and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 8, 2018.

IT IS SO ORDERED October 9, 2018.

MEDICAL BOARD OF CALIFORNIA

By: Ronald H. Lewis, MD
Roanld H. Lewis, M.D., Chair
Panel A

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PAULA N. ADESOKAN, M.D.** **629 Beaver Ruin Road** **Lilburn, GA 30047-3437** **Physician's and Surgeon's Certificate No. G 88987** Respondent.	Case No. 800-2018-041023 **DEFAULT DECISION AND ORDER** [Gov. Code §11520]

FINDINGS OF FACT

1. On or about July 19, 2018, Complainant Kimberly Kirchmeyer, in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Accusation No. 800-2018-041023 against Paula N. Adesokan, M.D. (Respondent) before the Medical Board of California.

2. On or about July 22, 2011, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G 88987 to Respondent. The Physician's and Surgeon's Certificate expired on October 31, 2014, and has not been renewed. (Exhibit Packet, Exhibit 1[1],

[1] The evidence in support of this Default Decision and Order is submitted herewith as the "Exhibit Packet."

Certificate of Licensure.)

3. On February 12, 2018, the Maryland State Board of Physicians revoked Respondent's license to practice medicine in Maryland, based on charges of unprofessional conduct, gross over-utilization of health services, and failure to cooperate with a lawful investigation. (Exhibit 2 to Exhibit Packet, Accusation and related documents.) On May 8, 2018, Respondent's license was suspended, and a no practice order issued, based on the out state discipline (Exhibit Packet, Exhibit 1.)

4. On or about July 19, 2018, an employee of the Board, served by Certified and First Class Mail a copy of the Accusation No. 800-2018-041023, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 629 Beaver Ruin Rd, Lilburn, GA 30047-3437. (Exhibit Packet, Exhibit 2, Accusation, related documents, and Declaration of Service.)

5. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

6. On or about August 9, 2018, the aforementioned documents were returned by the U.S. Postal Service marked "Not Deliverable as Addressed, Unable to Forward." (Exhibit Packet, Exhibit 3, envelope returned by the post office.)

7. A second address 4499 Garmon Road NW, Atlanta, GA 30327-3829 was obtained through Lexis Nexis. On August 13, 2018, an employee of the Board, served by Certified and First Class Mail a copy of the Accusation No. 800-2018-041023, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent at 4499 Garmon Road NW, Atlanta, GA 30327-3829. (Exhibit Packet, Exhibit 4, Accusation Packet served on Respondent.)

8. On September 4, 2018, an employee of the Attorney General's Office served by certified mail addressed to Respondent at 4499 Garmon Road NW, Atlanta, GA 30327-3829 a Courtesy Notice of Default. The Courtesy Notice of Default with a copy of Accusation and Notice of Defense advised Respondent that she was in default and she should take immediate

action and file a Notice of Defense, and cautioned her that a decision would be rendered by the Board without hearing if she did not take action. (Exhibit Packet, Exhibit 5, copy of Courtesy Notice of Default and proof of service.)

STATUTORY AUTHORITY

9. Business and Professions Code section 118 states, in pertinent part:

"(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the license on any such ground."

10. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 800-2018-041023.

11. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

12. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in the

Exhibit Packet, Exhibits 1, 2, 3, 4, and 5, finds that the allegations in Accusation No. 800-2018-041023 are true.

13. Section 2305 of the Code states:

"The revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under this chapter [Chapter 5, the Medical Practice Act] shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state."

14. Section 141 of the Code states:

"(a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the events related therein.

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

DETERMINATION OF ISSUES

Pursuant to the foregoing Findings of Fact, Respondent's conduct, and the action of the Maryland Board, constitute cause for discipline within the meaning of Business and Professions Code sections 2305 and 141(a).

DISCIPLINARY ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. G 88987, heretofore issued to Respondent Paula N. Adesokan, M.D., is **REVOKED**.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on November 7, 2018 at 5:00 p.m.

It is so ORDERED October 8, 2018

Kimberly Kirchmeyer, Executive Director
FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 19 2018
BY K. Wong ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PAULA N. ADESOKAN, M.D.** 629 Beaver Ruin Rd Lilburn, GA 30047-3437 Physician's and Surgeon's Certificate No. G 88987, Respondent.	Case No. 800-2018-041023 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 22, 2011, the Medical Board issued Physician's and Surgeon's Certificate Number G 88987 to Paula N. Adesokan, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on October 31, 2014, and has not been renewed. On May 8, 2018, the Medical Board served Respondent with a Notice of Out of State Suspension Order, reflecting that Respondent's license had been suspended effective immediately.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2305 of the Code states:

"The revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under this chapter [Chapter 5, the Medical Practice Act] shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state."

6. Section 141 of the Code states:

"(a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the events related therein.

"(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

STATEMENT OF FACTS

7. On or about February 12, 2018, the Maryland State Board of Physicians entered its final decision and order revoking Respondent's license to practice medicine in the State of Maryland, after Respondent failed to appear and defend charges in five separate cases against her. The circumstances are as follows:

Respondent is a board-certified dermatologist, who was the founder and principal owner of a dermatology and dermatopathology practice headquartered in Liburn, Georgia, with offices in several states including Pennsylvania, Georgia and Maryland. Respondent also co-owned a pathology laboratory with her husband, and served as the director of that laboratory.

- Case Number 2015-0264A: On or about October 20, 2014, a physician who worked in the same business complex as one of Respondent's clinics submitted a written complaint that a physician assistant was not being properly supervised, and that Respondent and other providers employed in the clinic were engaging in gross overutilization of health care services. The Maryland Board investigated and found evidence that for 15 separate patients, Respondent either failed to supervise a physician assistant, or grossly over utilized medical services providing services that

were redundant or not clinically appropriate, and otherwise engaged in unprofessional conduct.

- Case Number 2017-0010A: On or about July 7, 2016, the Maryland Board received an anonymous complaint from an alleged employee of Respondent, complaining that Respondent had received an eviction notice, maintained substandard office conditions and allowed unlicensed practitioners to perform procedures. Respondent submitted a written response to the Maryland Board that she had been investigated by the US Department of Justice for allegations regarding improper financial relationships with physicians in her employment, and that the investigation had culminated in an agreement effective April 21, 2015 to pay $3,247,635 plus interest at 2.375% annually to settle allegations that Respondent had violated the False Claims Act. Respondent informed the Maryland Board that Respondent had thereafter defaulted on this agreement, with the result that the practice had been excluded from participating in federal programs. Respondent stated she issued a temporary suspension of operations notice to staff on August 1, 2016, due to cash flow issues.
- Case Numbers 2017-0549A, 2017-0587A and 2017-0653A: On or about February 21, March 9 and March 30, 2017, the Maryland Board received three separate complaints from former patients that they had been unable to obtain copies of their medical records from Respondent.

After Respondent failed to appear at the duly noticed administrative hearing, the Maryland Board found Respondent in default and concluded as a matter of law that Respondent was guilty of unprofessional conduct in the practice of medicine, by referring pathology services from the clinics she owned to the laboratory she owned, without disclosing to her patients that she owned an interest in the laboratory; that Respondent was guilty of unprofessional conduct in that she grossly over utilized medical services based on multiple instances of redundant or not clinically proper medical services provided by Respondent or the clinicians she employed. The Maryland Board also concluded as a matter of law that Respondent had failed to provide patients with

details of their medical records; and that Respondent had failed to cooperate with the Maryland Board's lawful investigation and disciplinary process.

FIRST CAUSE FOR DISCIPLINE

(Discipline Restriction or Limitation Imposed by Another State)

8. Respondent Paula N. Adesokan, M.D. is subject to disciplinary action under section 2227, 2305 and 141 in that the state of Maryland issued an order revoking Respondent's medical license in that state effective February 12, 2018. The Maryland Order is attached as Exhibit A, and as described in paragraph 7, above, comprises unprofessional conduct and cause for discipline pursuant to sections 2305 and/or 141 of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 88987, issued to Paula N. Adesokan, M.D.;

2. Revoking, suspending or denying approval of Paula N. Adesokan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Paula N. Adesokan, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: July 19, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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IN THE MATTER OF	*	**BEFORE THE**
PAULA M. NELSON, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number D71962 (Expired)	*	**Case Numbers: 2015-0264A, 2017-0010A, 2017-0549A,**
	*	**2017-0587A & 2017-0653A**

* * * * * * * * * * * * *

FINAL DECISION AND ORDER

INTRODUCTION AND PROCEDURAL HISTORY

Paula M. Nelson, M.D., ("Respondent" or "Dr. Nelson,") a dermatologist, was initially licensed to practice medicine in Maryland on March 14, 2011. Dr. Nelson's license expired on September 30, 2017.[1] In 2014, the Maryland State Board of Physicians (the "Board") received a complaint alleging that a physician assistant was being improperly supervised and that Dr. Nelson and other providers were grossly overutilizing dermatologic procedures. The Board opened an investigation. In 2016, the Board received a second complaint from an anonymous "employee" alleging substandard office conditions, an eviction notice, and that unauthorized practitioners were performing procedures.

On January 12, 2017, Disciplinary Panel A ("Panel A") of the Board filed charges against Dr. Nelson alleging violations of § 14-404(a)(3)(ii) and (19) of the Health Occupations Article for unprofessional conduct in the practice of medicine and gross overutilization of health services, respectively. The charges also alleged violations of Health Occ. § 1-302(a)(1)-(3) and (d)(3) for prohibited referrals to a health care entity in

[1] A physician's medical license does not lapse while the individual is under investigation or while charges are pending. *See Health Occ. § 14-403(a).* Therefore, the Board maintains jurisdiction over Dr. Nelson's license for the purpose of these proceedings.

which the practitioner or the practitioner's family owns a beneficial interest or has a compensation arrangement. In addition, Panel A charged Dr. Nelson with failing to disclose the existence of a beneficial interest in a health care entity, in violation of Health Occ. § 1-303(a)-(b).

On February 7, 2017, Panel A delegated the charges to the Office of Administrative Hearings ("OAH") for an evidentiary hearing. On February 10, 2017, the Board received an email from Michael Smith who stated that he was an attorney licensed in Georgia who had been contacted by Dr. Nelson to represent her in this matter. On behalf of Dr. Nelson, he asked the Board to rescind its delegation to OAH, while he obtained admission in Maryland *Pro Hac Vice*. *See* Code of Maryland Regulations (COMAR) 10.32.02.03F(1), Maryland Rule 19-214. The Board agreed to Dr. Nelson's request and rescinded the delegation to OAH.

On February 21, March 9, and March 30, 2017, the Board received three separate additional complaints from three former patients alleging that they had been unable to obtain their medical records from Dr. Nelson's practice. The Board filed amended charges on May 1, 2017, adding to the previous charges Health Occ. § 14-404(a)(13) for failure to provide details of patients' medical records to the patient and § 14-404(a)(33), for failure to cooperate with a lawful investigation conducted by the Board or a disciplinary panel. Mr. Smith never obtained admission, *Pro Hac Vice*, and did not appear before Panel A on behalf of Dr. Nelson. On May 11, 2017, Panel A delegated the Amended Charges to OAH for an evidentiary hearing.

On May 17, 2017, OAH issued a notice of a scheduling conference for May 31, 2017, to Dr. Nelson's address of record with the Board. The United States Postal

Service did not return the notice to OAH. On May 18, 2017, the State mailed to Dr. Nelson a formal discovery request under COMAR 10.32.02.04C(1). Dr. Nelson did not respond to the State's discovery request or seek an extension of time for her response.

On May 31, 2017, the Administrative Law Judge ("ALJ") convened the scheduling conference. Dawn L. Rubin, Assistant Attorney General, appeared as the administrative prosecutor representing the State. The ALJ waited more than 15 minutes before proceeding without Dr. Nelson. At the conference, Ms. Rubin stated that on May 30, 2017, she received an email from Dr. Nelson notifying Ms. Rubin that Dr. Nelson did not intend to attend the scheduling conference.

On June 1, 2017, OAH issued a "Notice of In-Person Prehearing Conference" to the parties. Notice was mailed to Dr. Nelson at her address of record and was not returned by the postal service. The notice informed the parties that a prehearing conference would be held on July 17, 2017, at OAH in Hunt Valley, Maryland. The notice also informed the parties that a prehearing conference statement must be filed no later than 15 days before the scheduled prehearing conference and set forth the detailed required content of the prehearing conference statement.

On June 2, 2017, the ALJ issued a Scheduling Order instructing that the parties file prehearing conference statements on or before June 30, 2017 and that "[f]ailure to file a prehearing conference statement may result in a default being entered against a party." The notice was mailed to Dr. Nelson at her address of record and was not returned by the postal service. The State filed a prehearing conference statement. Dr. Nelson failed to file a prehearing conference statement. The Scheduling Order also

notified the parties of the time and date of the July 17, 2017, In-Person Prehearing Conference.

On July 11, 2017, Dr. Nelson filed a request to postpone the prehearing conference, claiming that she had not been able to retain counsel due to financial hardship. Dr. Nelson stated that she was working in Abu Dhabi and requested a postponement until September 2017.

On July 12, 2017, the State filed an objection to Dr. Nelson's postponement request and argued that: the Board gave Dr. Nelson repeated opportunities to respond to the charges and retain counsel; Dr. Nelson failed to file a timely prehearing statement; Dr. Nelson had sufficient time to retain counsel; Dr. Nelson failed to respond to the State's May 18 discovery request; and that the charges are serious and involve patient care.

The ALJ denied the postponement request, and the OAH Docket Specialist notified Dr. Nelson by telephone that her request had been denied.

On July 17, 2017, Ms. Rubin appeared for the State at the prehearing conference. Saul Jablon, Esquire, appeared for Dr. Nelson for the limited purpose of requesting a postponement. Mr. Jablon stated that he was contacted by Mr. Smith, the Georgia-licensed attorney, on July 13 or 14, 2017, and indicated that Mr. Smith was planning to represent Dr. Nelson pro bono. Mr. Jablon stated that he agreed to represent Dr. Nelson at OAH on July 17, and requested an extension of time for Mr. Smith to be admitted *Pro Hac Vice*.

The State opposed the postponement request and moved for a default judgment. Mr. Jablon opposed the motion for default. The State offered the exhibits it had planned to offer into evidence and those exhibits were put into the file by the ALJ.

Under OAH's rules of procedure, "[i]f, after receiving proper notice, a party fails to attend or participate in a prehearing conference, hearing, or other stage of a proceeding, the judge may proceed in that party's absence or may, in accordance with the hearing authority delegated by the agency, issue a final or proposed default order against the defaulting party." COMAR 28.02.01.23A.

On July 18, 2017, the Administrative Law Judge ("ALJ") granted the State's motion and issued a Proposed Default Order based on the OAH proceeding described above. The ALJ proposed that the Panel:

1. Find the Respondent in default;

2. Adopt as fact the statements set out in the Allegations of Fact section of the State's Amended Charges;

3. Conclude as a matter of law that Dr. Nelson violated Health Occ. § 14-404(a)(3)(ii), (13), (19), (33) and Health Occ. § 1-302(a)(1)-(3) and (d)(3), and section 1-303 (a)-(b), in the manner set forth in the State's Amended Charges; and

4. Revoke the Respondent's license to practice medicine.

According to OAH's rules of procedure regulations "[a] proposed default order is reviewable in accordance with the delegating agency's regulations governing review of proposed decisions." COMAR 28.02.01.23C. On August 4, 2017, Dr. Nelson filed exceptions, and an attorney, Jonathan Gladstone, appeared on her behalf at an

exceptions hearing held on October 25, 2017, before Disciplinary Panel B of the Board ("Panel B").

RULING ON THE DEFAULT JUDGMENT

In her exceptions, Dr. Nelson argues that a default was inappropriate because, under COMAR 28.02.01.23A and Health Occ. § 14-405, a disciplinary panel may issue a default order if a party fails to attend or participate in a prehearing conference. Dr. Nelson argued that she appeared and participated through her counsel Saul Jablon. Dr. Nelson also argued that she was available to participate in the prehearing conference via telephone. Dr. Nelson further argued that she gave the "timely, good cause reason" of her absence from the country as the reason she was unable to physically attend the prehearing conference and that her dire financial situation prevented her from traveling to physically appear at the hearing and made it difficult to retain counsel.

The State filed a response to Dr. Nelson's exceptions. The State argued that despite proper notice, Dr. Nelson failed to appear at the initial May 31, 2017, Scheduling Conference; failed to comply with the State's request for discovery; failed to file a prehearing conference statement on June 30, 2017, in violation of the ALJ's Scheduling Order; failed to appear or participate at the prehearing conference; and failed to request that she have the ability to appear telephonically. The State argued that Mr. Jablon, who had been hired only two days before the prehearing conference, was present merely to request the ALJ to reset the prehearing conference date and was not

prepared to address the issues in the prehearing conference instructions. Finally, the State argued that Dr. Nelson has continued to request continuances and has delayed Board proceedings, and has had ample time to prepare to defend the allegations in the matter.

On June 1, 2017, Dr. Nelson was sent a "Notice of In-Person Prehearing Conference" that advised Dr. Nelson of a prehearing conference on July 17, 2017. A prehearing conference is to allow the parties to resolve matters prior to the hearing, and ensure that the parties have the material necessary to prepare for the evidentiary hearing. *See generally* COMAR 28.02.01.17. The notice to Dr. Nelson specified that "[i]f special accommodations are required, please notify this office at least five days prior to the prehearing date." Dr. Nelson never requested to appear telephonically or any other accommodation. Enclosed with the notice were In-Person Prehearing Conference instructions, which requested among other things: a statement of the issues presented, a statement in support or in defense of the claim, a statement of facts expected to be in dispute or undisputed, a witness list, copies of exhibits to be introduced, the name and curriculum vitae of expert witnesses, a summary of the expert witness's testimony, prehearing motions and a statement of discovery disputes.

In a letter dated June 2, 2017, the ALJ reiterated to Dr. Nelson and the administrative prosecutor for the State, that an In-Person Prehearing Conference was scheduled for July 17, 2017. The ALJ highlighted that the parties were required to file the above-described prehearing statements with OAH and to serve a copy on the opposing party no later than June 30, 2017. The letter warned that "[f]ailure to file a timely prehearing conference statement may result in a default being entered against a

party. . . . [and f]ailure to appear for the prehearing conference . . . may result in a default order being entered." Despite these warnings, Dr. Nelson failed to submit a prehearing conference statement by the June 30th deadline. Dr. Nelson does not contest that she was given proper notice of the prehearing conference or the requirement to provide a prehearing conference statement by June 30, 2017. The State filed a prehearing statement on June 27, 2017, setting forth the factual and legal issues, an exhibit list, a witness list, an expert witness list, an expert *curriculum vitae* and report, and a list of undisputed matters.

On July 17, 2017, Dr. Nelson appeared at the prehearing conference through counsel, Saul Jablon. Mr. Jablon, however, did not meaningfully participate in the conference. When asked to present, Mr. Jablon requested a postponement, which he called "an extension of time" to allow Mr. Smith to be admitted to practice law in Maryland. When asked to respond to the motion for a default judgment, Mr. Jablon requested additional time to allow Mr. Smith to provide the discovery and other information for the prehearing conference.

Contrary to Dr. Nelson's argument to Panel B during the exceptions hearing, Mr. Jablon was not prepared to proceed with the prehearing conference or to provide the information required in the already overdue prehearing conference statement. Indeed, Dr. Nelson had not provided a single response to discovery nor responded in any way to the allegations in the charging document.

The Panel adopts the ALJ's conclusion that "Mr. Jablon appeared at the prehearing conference solely to request a postponement. He was not prepared to address the issues set forth in the prehearing conference instructions issued by the

OAH. Therefore, the Respondent failed to attend or participate in the Prehearing Conference." ALJ Proposed Decision at 5-6.

Dr. Nelson argues that she could not appear because she was physically located in Abu Dhabi and because she did not have the financial resources to travel or hire an attorney. None of those reasons excuse the failure to meaningfully participate at the prehearing conference. Neither excuse justifies her failure to provide basic information, such as the statement of the issues, a statement of disputed and undisputed facts, exhibits, or witnesses she intended to call in this complex case. Additionally, for the first time in her exceptions, Dr. Nelson informs the Panel that she was available telephonically on the date of the prehearing conference. There is simply nothing in the record to support the suggestion that Dr. Nelson was ready and available to participate telephonically. Dr. Nelson did not request from the ALJ prior to the prehearing conference any accommodation to appear telephonically, nor did Mr. Jablon raise the possibility of Dr. Nelson appearing telephonically to participate in the prehearing conference. The Panel finds that Dr. Nelson did not participate in the prehearing conference.

Dr. Nelson's failure to participate in the prehearing conference was not a one-time mistake. It is undisputed that Dr. Nelson failed to provided discovery to the State pursuant to COMAR 10.32.02.04C(1) and (3). That includes both mandatory discovery requirements as well as the State's May 18, 2017, request for a list of witnesses to be called, copies of documents to be produced at the hearing, the name and *curriculum vitae* of any experts, and a copy of expert reports. It is also undisputed that Dr. Nelson also declined to attend the scheduling conference where she was instructed to be ready

to discuss the requested and mandatory discovery, a list of witnesses to be called and exhibits to be offered into evidence, discovery motions, stipulations or any dispositive motions. Her only participation prior to the prehearing conference was a motion to postpone six days prior to the prehearing conference.

Further, Dr. Nelson's request for a postponement to allow time for Mr. Smith to be admitted in Maryland to represent Dr. Nelson fails as a valid excuse. Mr. Smith originally sent an email to the Board seeking time to obtain temporary local admission on February 10, 2017, over five months prior to the prehearing conference. The Panel agrees with the ALJ's statement that, prior to the request for postponement, Dr. Nelson did nothing to "indicate that she seriously intends to appear and contest these charges or participate in the hearing." The Panel, therefore, upholds the ALJ's default judgment.

FINDINGS OF FACT

Because Panel B concludes that Dr. Nelson has defaulted, the following findings of fact are adopted from the Allegations of Fact set forth in the May 1, 2017, Amended Charges Under the Maryland Medical Practice Act and are deemed proven by a preponderance of the evidence:

Background

1. At all times relevant, the Respondent was licensed to practice medicine in the State of Maryland. The Respondent was initially licensed on or about March 14, 2011, and her license expired on September 30, 2017.

2. At all times relevant, the Respondent held medical licenses in Alabama, California, Florida, Georgia, Illinois, Louisiana,[2] Massachusetts, North Carolina, New

[2] Dr. Nelson's Louisiana license became inactive during part of the relevant time period; from November 22, 2010 until October 31, 2014.

Jersey, Pennsylvania, South Carolina, Virginia, and Vermont. Her prior medical licenses included Arizona, Delaware, Texas, and Minnesota.

3. The Respondent was board-certified in dermatology and dermatopathology medicine.

4. At all times relevant, the Respondent resided in Georgia, and was the co-owner of a pathology laboratory ("Laboratory A")[3] with her husband (a non-physician) located in Atlanta, Georgia.

5. At all times relevant, the Respondent was the founder and principal owner of a dermatology and dermatopathology practice, ("Practice A") headquartered in Lilburn, Georgia.

6. The Respondent's husband, a non-physician, was the Manager of Practice A.

7. At all times relevant, Practice A owned offices in several different states including Pennsylvania, Georgia and Maryland.[4]

8. In September 2011, Practice A purchased two of its Maryland locations from a dermatologist, Physician A; specifically, in Westminster ("Location A") and Eldersburg ("Location B").

9. At times relevant, Practice A owned two additional locations in Maryland; in Cockeysville ("Location C") and Chevy Chase ("Location D").

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[3] In order to maintain confidentiality, facility, patient and employee names are not used in this document.

[4] The Department of Health and Human Services ("DHHS") filed suit against the Practice A in *United States ex rel. Ross v. Family Dermatology of Penn., P.C.*, No. 1:11-cv-2413 (N.D. Ga.); *United States ex rel. Baucom v. Family Dermatology of Penn., P.C.*, No. 1:11-cv-4260 (N.D. Ga.); and *United States ex rel. Milstein v. Family Dermatology, P.C.*, 1:13-cv-01027 (N.D. Ga.) alleging violations of the False Claims Act. Sometime around April 2015 Practice A entered into a confidential settlement agreement with DHHS as a resolution. On or about May 30, 2016, the Respondent was excluded from participation in Medicare and Medicaid and all Federal Health Programs for breach of Practice A's settlement agreement with DHHS. Consequently, the Respondent closed several of Practice A's locations.

10. After Physician A sold Locations A and B to Practice A, he became an independent contractor for Practice A through January 2014.[5] He supervised a physician assistant through January 2014, Physician Assistant A, who also remained on staff at Practice A at various locations.[6]

11. The Respondent practiced at several of the locations. For example, she saw patients at Locations A and B after Physician A left the practice (starting January 2014) on Thursdays, either weekly or every other week, and became the supervising physician for Physician Assistant A.

12. The Respondent was the Director of Laboratory A and sometimes was the reviewing pathologist for specimens submitted by employees and independent contractors from Practice A as set forth below. In addition to the Respondent, there were four other pathologists employed by Laboratory A at relevant times.

Complaint #1 (MBP Case # 2015-0264)

13. On or about October 20, 2014, the Board received a written complaint from a physician who worked in the same business complex as Location C, who alleged in part that Physician Assistant A was being improperly supervised and that the Respondent and other providers were engaging in gross overutilization of dermatologic procedures.[7]

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[5] The Respondent continued to see patients at Locations A and B, and also saw patients at Location C.

[6] Each practice location was staffed by physician assistants and physicians.

[7] The Respondent also named Physician A and Physician Assistant A in the complaint. The Board did not find evidence to support improper supervision of Physician Assistant A or that there was adequate evidence that Physician Assistant A violated the Physician Assistants Act.

14. The Board initiated an investigation of the allegations, which included conducting interviews, issuing a subpoena for medical and billing records from Practice A,[8] and requesting summaries of care from the Respondent on 15 randomly selected patients.

15. On or about July 30, 2015, the Board notified the Respondent of its investigation and requested a response.

16. On or about September 11, 2015, the Board requested summaries of care for the 15 patients identified in ¶ 14.

17. On or about September 24, 2015, the Board received a written response from the Respondent denying the allegations in the Complaint.

18. On or about November 13, 2015, the Respondent submitted summaries of care as requested on September 11, 2015, for 9 of the 15 patients identified in ¶ 16. She stated that she had not "seen" the other 6 patients.

19. In furtherance of its investigation, Board staff transmitted medical and billing records of 15 patients (identified below as Patients A through O) referenced in ¶ 14, and other relevant documents from the Board's investigative file to a physician board-certified in dermatology (the "Expert") for the purpose of conducting an independent expert review. The Expert's opinions are set forth in pertinent part below.

Complaint #2 (MBP Case # 2017-0010)

20. On or about July 7, 2016, the Board received an anonymous complaint from an "employee" alleging several potential violations including but not limited to receipt of an eviction notice, substandard office conditions and that unauthorized practitioners had been performing procedures.

[8] Board staff initially subpoenaed 44 patient records from Practice A from Locations A, B and C. Practice A sent to the Board 43 records, and of those records, Board staff selected 15 for review.

21. On or about August 5, 2016, the Board notified the Respondent of the anonymous complaint and requested a written response.

22. On or about September 1, 2016, the Respondent submitted a written response to the Board stating that Practice A had been investigated by the United States Department of Justice ("DOJ") for allegations of "engaging in improper financial relationships with a number of its employed physicians." She further stated in part:

> ...
>
> The investigation culminated in the execution of an agreement with the DOJ, effective April 21, 2015 to pay $3,247,835 plus interest at 2.375% annually, to be paid in 7 installments over five years...The settlement was to 'settle allegations that [Practice A] violated the False Claims Acts [sic] by engaging in improper financial relationships with a number of its employed physicians. The settlement agreement is not an admission of liability.'
>
> On May 18, 2016, the OIG[9] issued an exclusion letter excluding [Practice A] from participation in federal programs...The OIG's exclusion letter was issued as a result of [Practice A] defaulting on its payment obligations pursuant to a Settlement Agreement with DHHS, DOJ and OIG...

23. The Respondent denied the allegations of unauthorized practice, and stated that "Due to cash flow issues...we issued a temporary suspension of operations letter to our staff on August 1, 2016..."

24. The investigation of complaints 2015-0264A and 2017-0010A are set forth below.

Complaints # 3-5 (MBP Case ## 2017-0549A, 2017-0587A & 2017-0653A)

25. In 2017, on or about February 21, March 9 and March 30, the Board received three separate complaints respectively from three former patients (P, Q and R) alleging they had been unable to obtain their medical records from Practice A as set forth below in ¶¶ 158-172.

[9] OIG refers to Office of the Inspector General.

Respondent's Interviews

March 4, 2016

26. On or about March 4, 2016, Board staff conducted a telephonic interview of the Respondent under oath with regard to the allegations cited in the complaint.

27. The Respondent stated that she was the principal owner of Practice A and was responsible for focusing on patient care.

28. The Respondent's husband managed Practice A which includes overseeing the purchases of dermatology practices. According to the Respondent, her husband was responsible for the transitions of Practice A's newly acquired locations.

29. The Respondent stated that Practice A provided the computer systems and electronic medical record systems to the various locations. Practice A provided the medical billing for all of the locations. The billing department was located in Atlanta, Georgia.

30. The Respondent stated that she and her husband had owned Laboratory A since approximately 2001.

31. The Respondent stated that the "management" of Practice A discussed with physician-owners the process for sending specimens to Laboratory A when negotiating the purchase of their respective practices.

32. The Respondent stated that Laboratory A provided Practice A's providers with electronic medical records containing a link to the pathology reports and the turnaround time was "quick."

33. The Respondent stated that she "believe[d]" the consent forms signed by Patient A's patients disclosed that the specimens were sent to a particular laboratory, such as Laboratory A.

October 18, 2016

34. On or about October 18, 2016, Board staff interviewed the Respondent under oath in person.

35. The Respondent stated that specimens from Practice A were routinely sent to Laboratory A.

36. The Respondent stated that other providers "send to other labs and we let them decide."

37. The Respondent stated that she sent all the specimens she obtained to Laboratory A, unless the patient said they did not want the specimen sent to Laboratory A.

38. The Respondent stated that Practice A had a protocol in which the specimens were checked, placed in a FedEx bag and sent off to Laboratory A.

39. If the Respondent was working late on a Thursday night (she specified at Location C), she would "take [the specimen] back to Atlanta" and deliver it to Laboratory A.

40. The Respondent stated that on occasion after she obtained a specimen from a patient, she would also conduct the pathology review. The Respondent acknowledged that other providers from Practice A would obtain specimens sent to Laboratory A for her to review.[10]

[10] As set forth below in ¶60, several providers other than the Respondent obtained the specimens and three different pathologists (other than the Respondent) conducted reviews of the specimens.

Employee A

41. On or about May 12, 2016, Board staff made site visits to Locations A and B, and interviewed the Office Manager for Locations A and B ("Employee A").

42. Employee A worked at Locations A and B for 28 years, initially when Physician A had owned the practices. Employee A remained on staff following Physician A's sale of Locations A and B.

43. Employee A stated that she was aware that the Respondent owned Laboratory A. She stated that the staff was not "required" to send specimens to Laboratory A, but acknowledged that Practice A routinely sent specimens to Laboratory A for patients who were insured by Medicare and Medicaid.

Physician A

44. On or about March 2, 2016, Board staff interviewed Physician A by telephone under oath.

45. During the sworn interview, Physician A confirmed that he contacted Practice A for the purpose of selling his practice locations ("Locations A and B") sometime in 2011.

46. Physician A further confirmed that he finalized the sale of his practice on or about September 1, 2011, and he became an independent contractor for Practice A. Physician A remained at Practice A as an independent contractor through January 2014.

47. According to Physician A, Practice A took over his billing, and the day-to-day operations. The employees that remained became employees of Practice A.

48. According to Physician A, he received payment based on a formula which was a percentage of the collections minus certain overhead. His reimbursement was based on a standard formula that Practice A had negotiated with other providers.[11]

49. Physician A stated that he sent specimens to Laboratory A, but he also sent specimens to other laboratories.

Physician B

50. On or about April 29, 2015, Board staff interviewed Physician B by telephone under oath.

51. Physician B is a dermatologist who sold his Chevy Chase dermatology practice to Practice A in June 2011.

52. According to Physician B, he remained in the practice as an independent contractor providing dermatologic care at Location D with one other part-time physician, after selling his practice.

53. In compensation for his practice, Physician B received from Practice A a monthly acquisition payment and a percentage of charges for any patients he treated.

54. After the sale of Physician B's practice, Practice A conducted all the billing for Location D. Practice A installed its own computer system for billing.

55. Employee B, located in Georgia, was Physician B's (and Location D's) contact person for billing and day-to-day issues such as supplies.

56. According to Physician B, Practice A's representatives told him on the purchase of his practice, that Practice A owned Laboratory A and that they would provide all the supplies necessary to send all of his "biopsy material" by "Fed Ex" to the Lab.

[11] According to Physician A, he contacted 4-5 providers that had sold their practices to Practice A, and the contracts entered into were the same as the contract Practice A offered to him.

According to Physician B, it was "the implied understanding" when they made the offer to purchase his practice that he would send his biopsy specimens to Laboratory A.

57. According to Physician B, Practice A made it very "easy" to use Laboratory A. Practice A facilitated the process for specimens to be sent to Laboratory A by providing bottles for the biopsy specimens and "Fed Ex" boxes. Physician B referred to the process of sending his specimens to Laboratory A as a "safe harbor" as he was not an "employee" but an "independent contractor."

58. According to Physician B, Fed Ex came almost every day to Practice D to pick up the biopsy specimens to be sent to Laboratory A.

59. Prior to selling his practice to Practice A, Physician B stated that he had sent his pathology specimens to other laboratories.

Records review

60. Pathology reports from October 2011 through May 2015 for Patients A through O reflect that of the 47 specimens obtained by Practice A's providers in Locations A, B and C, all were initially sent to Laboratory A for pathology review as set forth below:[12]

	Patient	Date	Specimen	Provider	Lab	Pathologist
1	A	4/10/2012	right cheek (basal cell carcinoma)	Physician A	A	Physician D
2	B	10/12/2011	neck (cyst)	Physician A	A	Respondent
3	B	10/18/2012	neck (cyst)	Physician A	A	Respondent
4	B	1/9/2013	left abdomen (basal cell carcinoma), right lower back (basal cell carcinoma)	Physician A	A	Respondent

[12] Four of the specimens initially sent to Laboratory A were subsequently sent to "outside" laboratories. Practice A submitted a laboratory slip to Laboratory A for Patient H for a biopsy of the hand that was taken on January 20, 2015, but failed to submit the specimen.

5	C	10/20/2011	left arm (basal cell carcinoma), right mid back (basal cell carcinoma), right back	Physician A	A	Physician D
6	C	3/8/2012	nose	Physician Assistant E	A	Respondent
7	D	8/9/2013	right breast (not reviewed by Lab A)	Physician Assistant D	A (and then subsequently to an outside lab)	Physician C
8	D	10/25/2013	right cheek (basal cell carcinoma)	Physician Assistant D	A	Physician F
9	E	1/21/2013	left ear (basal cell carcinoma)	Physician A	A	Respondent
10	E	3/20/2013	left antecubital arm (malignant melanoma in situ)	Physician Assistant D	A	Physician C (case reviewed with Respondent)
11	E	3/27/2013	left antecubital arm (no residual melanoma)	Physician E	A	Physician C
12	E	4/8/2013	left shoulder (atypia and dysplasia)	Physician Assistant D	A	Respondent
13	E	4/25/2013	left shoulder	Physician Assistant D	A	Physician C
14	E	8/7/2013	right temple (not reviewed by Lab A)	Physician Assistant D	A (subsequently sent to outside lab)	Physician C
15	E	7/14/2014	left lower back	Physician Assistant C	A	Respondent
16	E	5/12/2015	scalp	Physician Assistant C	A	Physician C
17	F	4/3/2012	left posterior lower leg (atypia and dysplasia), left posterior upper calf, mid back (atypia and dysplasia)	Physician Assistant A	A	Physician C
18	F	4/12/2012	left posterior lower leg (re-excision)	Physician E	A	Physician D
19	F	10/23/2012	right upper arm (melanoma)	Physician Assistant A	A	Physician D (discussed with Physician C)

20	F	11/1/2012	right upper arm (re-excision)	Physician E	A	Physician D
21	F	4/9/2013	thigh (three locations) (atypia and mild dysplasia)	Physician Assistant A	A	Physician D
22	F	8/27/2013	right upper back (not reviewed by Lab A)	Physician Assistant A	A (subsequently sent to outside lab)	Physician C
23	G	5/19/2014	Scalp (basal cell carcinoma)	Physician Assistant A	A	Physician C
24	G	1/20/2015	left dorsal hand	Physician Assistant A	A	Respondent
25	H	11/7/2013	left lower lip (squamous cell carcinoma in situ)	Physician Assistant B	A	Physician F
26	H	1/20/2015	left hand	Physician Assistant A	A-lab slip sent to Lab A but biopsy not performed	Respondent
27	H	2/3/2015	left lower lip (re-excision)	Physician Assistant A	A	Physician C
28	I	1/13/2014	left forehead (basal cell carcinoma), left sideburn (squamous cell carcinoma in situ)	Respondent	A	Physician C
29	I	6/26/2014	right upper arm (squamous cell carcinoma in situ)	Physician Assistant F	A	Respondent
30	J	5/15/2012	right cheek	Physician A	A	Physician D
31	J	3/24/2014	left ear (basal cell carcinoma)	Physician Assistant A	A	Physician C
32	L	5/20/2014	scalp (squamous cell carcinoma in situ), right cheek (squamous cell carcinoma in-situ)	Physician Assistant A	A	Physician C
33	M	1/3/2013	right forehead (basal cell carcinoma), left forehead, left upper arm (basal cell	Physician A	A	Physician D

			carcinoma)			
34	M	2/25/2013	left upper arm (residual basal cell carcinoma)	Physician Assistant D	A	Physician D
35	N	1/27/2012	right upper back (atypia/dysplasia)	Physician Assistant A	A	Physician D
36	N	2/15/2012	right upper back (dysplasia)	Physician E	A	Respondent
37	N	7/1/1/2013	right forehead, left corner of eye	Physician Assistant A	A (but then subsequently sent to outside lab)	Physician C
38	N	7/8/2014	left shoulder (squamous cell carcinoma)	Physician Assistant A	A	Respondent
39	O	10/18/2012	mid-back (atypia/dysplasia)	Physician A	A	Physician D
40	O	11/5/2012	mid-back	Physician A	A	Physician D
41	O	5/7/2013	right lower back (atypia, dysplasia)	Physician A	A	Respondent
42	O	6/20/2013	right lower back (re-excision)	Physician A	A	Respondent
43	O	10/8/2013	left sideburn (basal cell carcinoma), left flank	Physician Assistant D	A	Physician C
44	O	9/16/2014	left clavicle (basal cell carcinoma), right upper back	Physician Assistant A	A	Physician C
45	O	9/30/2014	left clavicle (basal cell carcinoma)	Physician Assistant C	A	Physician C
46	O	10/14/2014	central chest at throat (basal cell carcinoma)	Physician Assistant C	A	Respondent
47	O	11/6/2014	central chest at throat (basal cell carcinoma)	Physician Assistant C	A	Respondent
48	O	5/5/2015	right shoulder	Physician Assistant A	A	Physician C

61. Of the 47 specimens taken, only one biopsy specimen was obtained by the Respondent (#28).[13] All other biopsies documented were obtained by providers who were either independent contractors[14] or employees of Practice A.

62. Of the 47 specimens sent to Laboratory A, 15 of the specimens were reviewed by the Respondent (## 2, 3, 4, 6, 9, 12, 15, 24, 29, 36, 38, 41, 42, 46, and 47).[15]

63. There was no informed consent or notification in the 15 patient records reviewed notifying patients that the Respondent (as owner of Practice A) was also the owner of Laboratory A.

Patient-related findings

Patient A

64. Patient A, a female in her 90s, was treated by Practice A in 2012, from approximately March through December. Patient A was insured by Medicare and Blue Cross Blue Shield.

65. On April 10, 2012, Patient A had an "excision" (removal) of a lesion on her cheek performed by Physician A that was sent to Laboratory A for pathology review.[16]

66. The pathologist, Physician D, determined that Patient A had basal cell carcinoma

67. Although Physician A performed an excision, he documented treatment of the basal cell carcinoma with cryotherapy on both April 24, 2012 and June 5, 2012.

[13] The Respondent was not the assigned pathologist on this specimen. Another pathologist employed by Laboratory A, Physician C, conducted the review.
[14] Reimbursed based on a percentage of billings.
[15] There was no documentation in the patient records of these 15 patient specimens that the Respondent had either obtained the specimens or that she had directly supervised the providers who had obtained the specimens.
[16] Physician A billed it as an excision, which is intended as a removal of the lesion.

Treatment of the same lesion by excision and cryotherapy on two occasions within two months is evidence of overutilization of treatment procedures.

68. The Respondent was the principal owner of Practice A.

69. The Respondent, as owner of Practice A, received financial benefit from Physician A's overutilization and subsequent billing.

70. Practice A's provider services to Patient A that were redundant or not clinically appropriate constituted evidence of unprofessional conduct in the practice of medicine and the gross overutilization of health care services.

Patient B

71. Patient B, a male in his 70s, was treated by Practice A (Physician A) from approximately October 2011 through April 2013. Patient B was insured by Medicare and Blue Cross Blue Shield.

72. Physician A conducted biopsies of Patient B on three separate dates: October 2011 (neck); October 2012 (neck) and January 2013 (abdomen and right lower back).

73. Patient B's biopsy specimens were referred by Physician A to Laboratory A, and the Respondent was the pathologist.

74. On October 6, 2011, Physician A performed cryotherapy on Patient B's ears for "actinic keratosis."[17] Practice A billed Patient B's insurance companies for care rendered by Physician A including destruction of a malignancy of the scalp, neck, hands and feet. There is no documentation that Physician A treated a malignancy on this date.

[17] Rough, scaly patch that develops on the skin following sun exposure, a small percentage of which develop into skin cancer.

75. Practice A submitted bills to Patient B's insurance companies for care rendered by Physician A on December 28, 2011, March 7, 2012, March 28, 2012 and June 6, 2012 for destruction of a malignancy. There was no documentation in Patient B's record that he was treated for malignancies on those dates.

76. On January 9, 2013, Physician A conducted shave biopsies of lesions on Patient B's abdomen and right lower back, and referred the biopsies to Laboratory A for review. The Respondent, the assigned pathologist, reviewed the lesions as basal cell carcinoma. Practice A erroneously billed these shave biopsies conducted by Physician A as "excisions" instead of biopsies.

77. On February 2013, Patient B opted to be treated with liquid nitrogen instead of undergoing excisions of the lesions.

78. The Respondent was the principal owner of Practice A.

79. Practice A, based on Physician A's patient care, billed for services not provided as outlined in pertinent part above.

80. The Respondent, as owner of Practice A, received financial benefit from Physician A's billing.

81. Practice A's billing for services not rendered, or billing for services to Patient B that were redundant or not clinically appropriate, constituted evidence of unprofessional conduct in the practice of medicine and the gross overutilization of health care services.

Patient C

82. Patient C, a male in his 60s, was treated by Practice A from approximately October 2011 through July 2013, at Location A. Patient C was insured by Blue Cross Blue Shield.

83. During his care at Practice A, Patient C underwent biopsies conducted by Physician A on October 20, 2011 (left arm and two of the back) and March 8, 2012 by Physician Assistant E (nose).

84. Two of the October 20, 2011 biopsy specimens were positive for basal cell carcinoma.

85. The March 8, 2012 biopsy was normal. The Respondent was the pathologist.

86. On September 18, 2012, Physician A documented that he had treated a "superficial" basal cell carcinoma on Patient C's lower back with cryosurgery. There was no corresponding pathology report, or documentation that he had biopsied the site.

87. On November 5, 2012, Physician A documented he treated Patient C's back and mid-back with liquid nitrogen for basal cell carcinoma. There was no corresponding pathology report, or documentation that he had biopsied the sites. Practice A billed Patient C's insurance companies for destruction of malignancies.

88. On December 3, 2012, January 21, 2013, March 21, 2013, May 23, 2013, and July 5, 2013, Practice A billed for skin cancer destruction codes. There was again no corresponding pathology report, or documentation that Physician A had biopsied the site.

89. The Respondent was the principal owner of Practice A.

90. The Respondent, as owner of Practice A, received financial benefit from its providers' billing.

91. Practice A's provider services to Patient C that were redundant or not clinically appropriate, constituted evidence the Respondent engaged in gross overutilization of health care services and unprofessional conduct in the practice of medicine.

Patient D

92. Patient D, a female in her 80s, was treated by Practice A from approximately October 2011 through December 2013, at Location B. Patient D was insured by Medicare and Blue Cross Blue Shield.

93. On January 17, 2012, Physician A diagnosed Patient D with basal cell carcinoma of the scalp and skin of neck and skin of trunk; however, there was no corresponding pathology report in her medical record. On this date, Practice A billed Patient D's insurance company for Physician A's destruction of a malignancy for Patient D, but there was no documented treatment in Patient D's medical record. Physician A documented that he treated Patient D for "actinic keratosis," a benign condition, with cryotherapy. Yet, Practice A billed Patient D's insurance companies for Physician A's destruction of a malignancy.

94. On November 13, 2012, Physician A "diagnosed" Patient D with squamous cell carcinoma of her upper arm; however, there was no corresponding pathology report in her medical record. Physician A documented he treated Patient D's actinic keratosis and squamous cell carcinoma with cryotherapy.

95. The Respondent was the principal owner of Practice A.

96. The Respondent, as owner of Practice A, received financial benefit from its providers' billing.

97. Practice A's billing for services not provided or conducting procedures not clinically appropriate as outlined in pertinent part above constituted evidence the Respondent engaged in unprofessional conduct in the practice of medicine.

Patient F

98. Patient F, a female in her 60s to 70s, was treated by Practice A from approximately March 2012 through March 2015 at Locations A and B. Patient F was insured by Medicare and Blue Cross Blue Shield.

99. Patient F was treated by Physician Assistant A, Physician A, and Physician E.

100. On or about November 1, 2012, Physician E removed a melanoma lesion from Patient F's right upper arm. Physician E simultaneously billed for two repair codes for the removal of the lesion (CPT codes 13121 and 13122),[18] which reflect codes for two different lengths of repairs.

101. The Respondent was the principal owner of Practice A.

102. The Respondent, as owner of Practice A, received financial benefit from its providers' billing.

103. Practice A's overbilling for services rendered to Patient F as outlined in pertinent part above, constituted evidence the Respondent engaged in unprofessional conduct.

Patient G

104. Patient G, a male in his 70s, was treated by Practice A from approximately September 2011 through January 2015, at Locations A and B. Patient G was insured by Medicare and Blue Cross Blue Shield.

105. Patient G was treated by the Respondent, Physician A and Physician Assistant A.

106. On or about September 22, 2011, Patient G was seen by Physician A and diagnosed with basal cell carcinoma of the scalp/neck. Practice A billed Patient G's insurance companies for destruction of a malignancy.

[18] CPT, the abbreviation for Current Procedural Terminology, is the code set maintained by the American Medical Association.

107. On November 10, 2011, Physician A again saw Patient G for a skin cancer check, and noted that the spot on Patient G's scalp that was treated with liquid nitrogen was healing well. Physician A again treated the scalp area with liquid nitrogen.

108. On May 19, 2014, Physician Assistant A performed a shave biopsy of Patient G's scalp lesion. The pathology was read as basal cell carcinoma, fragmented.

109. On or about June 16, 2014, the Respondent saw Patient G. She documented that Patient G had a history of basal cell carcinoma of the right frontal scalp for several months, and evaluated him for a possible Mohs procedure.[19] The Respondent documented that she presented the treatment options to Patient G, and stated that "Mohs...surgery which gives a 99+% cure rate ... is reserved for recurrent tumors, aggressive tumors, or tumors in areas of high recurrence."

110. On July 7, 2014, the Respondent conducted Mohs surgery on Patient G's scalp lesion.

111. The Expert opined that repeated biopsies and/or treatments to the same scalp lesion were redundant and not clinically indicated.

112. The Respondent was the principal owner of Practice A.

113. The Respondent, as owner of Practice A, received financial benefit from its providers' billing.

114. The Respondent's services to Patient G and/or Practice A's provider services to Patient G that were redundant or not clinically appropriate as outlined in pertinent part above, constituted evidence the Respondent engaged in unprofessional conduct and gross overutilization of health care services.

Patient H

[19] Mohs surgery is a precise surgical technique used to treat skin cancer.

115. Patient H, a female in her 60s, was treated by Practice A from approximately August 2013 through May 2015, at Locations A and B. Patient H was insured by Blue Cross Blue Shield and Medicare.

116. Patient H was treated by several different providers at Practice A, including the Respondent.

117. On November 7, 2013, Physician Assistant B biopsied a lesion of Patient H's lower lip, which was sent to Laboratory A for review. The result was squamous cell carcinoma *in situ*.

118. On January 8, 2014, Physician Assistant A treated Patient H's carcinoma *in situ* referenced in ¶ 118 with liquid nitrogen.

119. On March 21, 2014, the Respondent conducted Mohs surgery of the same lip site, referenced in ¶¶ 117 and 118.

120. The next year, on or about February 3, 2015, Physician Assistant A re-excised / biopsied the same lower lip lesion and it was sent once again to Laboratory A for evaluation. The results were normal.

121. The Respondent was the principal owner of Practice A.

122. The Respondent, as owner of Practice A, received financial benefit from its providers' billing.

123. The Respondent was one of Patient H's clinical providers.

124. Practice A's provider services to Patient H were redundant and/or not clinically appropriate, and constituted evidence the Respondent engaged in unprofessional conduct and gross overutilization of health care services.

Patient I

125. Patient I, a male in his 70s, was treated by Practice A from approximately September 2011 through April 2015, at Location C. Patient I was insured by Blue Cross and Blue Shield and Medicare.

126. Patient I was seen by several providers at Practice A including the Respondent, and treated for various skin lesions of the face and arm.

127. On or about March 6, 2012, Patient I was seen by Physician A for a skin check. Physician A documented his assessment to include that Patient I had basal cell carcinoma of the skin and squamous cell carcinoma of the upper limb. Above these listed diagnoses, Physician A documented, "...examination of the all [*sic*] within normal limits." Physician A did not document that he had conducted biopsies on this date, or that he had treated Patient I.

128. Practice A submitted an invoice to Medicare and Blue Cross Blue Shield for care rendered by Physician A on March 6, 2012 (and received payment) for "destruction, malignant, scalp, neck, hands, feet" and "destruction by any method, benign/ premalignant, 1st lesion."

129. The Respondent was the principal owner of Practice A.

130. The Respondent, as owner of Practice A, received financial benefit from its providers' billing.

131. The Respondent was one of Patient I's clinical providers.

132. Practice A's billing for services not rendered as outlined in pertinent part above constituted evidence the Respondent engaged in unprofessional conduct in the practice of medicine.

Patient L

133. Patient L a male in his 70s, was treated by Practice A from approximately December 2011 through June 2015, at Locations B and C. Patient L was insured by Medicare and Blue Cross Blue Shield.

134. Patient L was treated by providers including Physician Assistant A, Physician A and the Respondent, for various skin lesions primarily on the shoulder, hands, arms, scalp and face.

135. Physician Assistant A was under the supervision of the Respondent from January 2014 until July 2015.

136. On May 20, 2014, Physician Assistant A saw Patient L for biopsies of lesions of his right cheek and scalp, and conducted excisions of both areas. The pathologist documented "focal areas" of squamous cell carcinoma *in situ*.

137. On June 17, 2014, Patient L returned to see Physician Assistant A and she re-treated the excisions of the cheek and scalp with liquid nitrogen.

138. The Respondent was the principal owner of Practice A.

139. The Respondent, as owner of Practice A, received financial benefit from its providers' billing, and Physician Assistant A was under her supervision.

140. The Respondent was one of Patient L's clinical providers.

141. Practice A's provider services to Patient L were redundant and/or not clinically appropriate, and constituted evidence the Respondent engaged in unprofessional conduct and gross overutilization of health care services.

Patient O

142. Patient O, a male in his 60s, was treated by Practice A from approximately December 2011 through May 2015, at Locations B and C. Patient O was insured by Medicare and Blue Cross Blue Shield.

143. Patient O was treated by providers including but not limited to the Respondent, Physician Assistant A and Physician A, for lesions on his back, shoulder and arm. He had a history of melanoma on his back from 1998, dysplastic nevus syndrome and basal cell carcinoma.

144. On May 14, 2012, Patient O saw Physician A for a full body examination. Physician A had seen Patient O previously at Practice A on December 5, 2011, for a full body examination.

145. Practice A (for Physician A's services) billed Patient O's insurance company for a new patient consultation (CPT code 99244) on May 14, 2012 despite having provided the same service five months earlier.

146. On October 18, 2012, Patient O returned to see Physician A for a skin examination. Physician A conducted two shave biopsies of lesions on Patient O's upper and lower mid back, and told Patient O to return to the office in three months. The results showed both to be dysplastic nevi with atypia.

147. Practice A (for Physician A's services) billed Patient O's insurance company for an excision for each (CPT code 11402), despite having documented that he had only conducted shave biopsies.

148. On November 5, 2012, Patient O returned to Practice A and saw Physician A for re-excision to remove the two dysplastic nevi. Physician A documented that he conducted excisions of the two sites that he had biopsied on October 18.

149. The pathology report prepared for the specimens submitted from November 5, 2012 noted that the biopsy specimens were "re-shave[s]",[20] yet Practice A (for Physician A's services) again billed CPT code 11402 for two excisions conducted on the same sites documented on October 18.

150. A few months later, on May 7, 2013, Patient O saw Physician A for a skin check, and Physician A again conducted a shave biopsy of the same lesion on Patient O's right lower back (biopsied on October 18 and November 6, 2012). Again, Practice A (for Physician A's services) billed Patient O's insurance company for an excision of a benign lesion (CPT code 11402) instead of a shave biopsy (CPT code 11302).

151. The Respondent was the reviewing pathologist for the May 7, 2013 shave biopsy specimen, and diagnosed the lesion as severe dysplastic nevus, requiring "complete re-excision." She billed Patient O's insurance company for surgical pathology, gross and microscopic ($180) and immunohistochemistry ($370).

152. There was no documented justification in Patient O's record for the Respondent to conduct immunohistochemistry staining.

153. Approximately one month later, on June 20, 2013, Physician A conducted a "re-excision" of a right lower back lesion, which showed the margins to be free of residual melanocytic lesion. The Respondent was the reviewing pathologist.

154. The Respondent was the principal owner of Practice A.

155. The Respondent, as owner of Practice A, received financial benefit from its providers' billing.

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[20] Re-shaves should have been coded as CPT code 11302.

156. Practice A's provider services to Patient O were redundant and/or not clinically appropriate, and constituted evidence that the Respondent is guilty of unprofessional conduct and gross overutilization of health care services.

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Patient P

157. On or about February 21, 2017, Patient P, a former female patient of Practice A, Location B, filed a complaint with the Board alleging she had attempted unsuccessfully on multiple occasions to obtain a copy of her medical records from Location B. She requested the Board's assistance in obtaining her records.

158. Patient P alleged that she had a history of moderate to severe skin conditions, and she was seeking her former records to provide to her present dermatologist.

159. When she contacted Location B by telephone in September and October 2016, no one answered the telephone.

160. Patient P contacted Practice A's Pennsylvania location, and the staff person who answered the call directed her to file a complaint.

161. By letter dated March 3, 2017, Board staff notified the Respondent of Patient P's complaint and requested a response within 10 days.

162. The Respondent failed to respond to the Board's request.

Patient Q

163. On or about March 9, 2017, Patient Q, a former male patient of Practice A, Location A, filed a complaint with the Board alleging that since the practice had "gone out of business" he had been unable to obtain his medical records to transfer the information to his new physician.

164. Patient Q stated in his complaint that he had attempted unsuccessfully to contact Location A by telephone and email.

165. By letter dated March 9, 2017, Board staff notified the Respondent of Patient Q's complaint and requested a written response within 10 days.

166. The Board did not receive a response from the Respondent.

Patient R

167. On or about March 30, 2017, Patient R, a former female patient of Practice A, Location B, filed a complaint with the Board alleging that she was unable to obtain her former medical records.

168. Patient R was a former patient of Physician A, Physician G and Physician Assistant A. She stated in her complaint that she had requested her medical records from Practice A to be sent to her new practice location over a year ago.

169. Practice A failed to provide Patient R's new practice location with her medical records.

170. On or about April 3, 2017, Board staff notified the Respondent of Patient R's complaint and requested a response.

171. The Board did not receive a response from the Respondent.

172. Respondent's failure to provide details of a patient's medical record to Patients P, Q, and R constituted evidence that Respondent is guilty of failing to provide details of a patient's medical record to patients.

173. Respondent's failure to respond to Board requests for a response to the complaints for Patients P, Q, and R constituted evidence of a failure to cooperate with a lawful investigation by the Board or disciplinary panel.

CONCLUSIONS OF LAW

Panel B adopts the ALJ's proposed default order issued pursuant to COMAR 28.02.01.23A. Panel B thus finds Dr. Nelson in default based upon her failure to participate at the Office of Administrative Hearings for the prehearing conference scheduled for July 17, 2017. *See* State Gov't § 10-210(4).

Based upon the foregoing findings of fact, Panel B concludes as a matter of law that Dr. Nelson is guilty of: unprofessional conduct in the practice of medicine by violating Health Occ. § 1-302(a) by referring, or directing its employees of or person under contract with Practice A to refer pathology services to Laboratory A; and assuming any of the referrals were exempted under Health Occ. § 1-302(d), Dr. Nelson also failed to adequately disclose her beneficial interest in Laboratory A consistent with Health Occ. § 1-303 to those patients referred. Dr. Nelson is also guilty of unprofessional conduct, in violation of Health Occ. § 14-404(a)(3)(ii), and gross overutilization of health care services, in violation of Health Occ. § 14-404(a)(19), based on Dr. Nelson's conduct as the clinical provider and owner of Practice A, as found, in pertinent part, in the findings of fact ¶¶ 64 through 156.

Dr. Nelson failed to provide details of patients' medical records to her patients, in violation of Health Occ. § 14-404(a)(13); and failed to cooperate with a lawful investigation by the Board or disciplinary panel, in violation of Health Occ. § 14-404(a)(33) as outlined in pertinent part in ¶¶ 157 through 173.

SANCTION

Panel B adopts the sanction recommended by the ALJ, which is to revoke Dr. Nelson's license to practice medicine in Maryland.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel B, hereby

ORDERED that Paula Nelson, M.D.'s license to practice medicine in Maryland (License Number D71962) is hereby **REVOKED**; and it is further

ORDERED that this is a public document.

02/12/2018
Date

Christine A. Farrelly
Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

I HEREBY ATTEST AND CERTIFY UNDER PENALTY OF PERJURY ON 04/24/2018 THAT THE FORGOING DOCUMENT IS A FULL, TRUE AND CORRECT COPY OF THE ORIGINAL ON FILE IN MY OFFICE AND IN MY LEGAL CUSTODY.

Christine A. Farrelly
EXECUTIVE DIRECTOR
MARYLAND BOARD OF PHYSICIANS

NOTICE OF RIGHT TO PETITION FOR JUDICIAL REVIEW

Pursuant to Md. Code Ann., Health Occ. § 14-408(a), Dr. Nelson has the right to seek judicial review of this Final Decision and Order. Any petition for judicial review shall be filed within 30 days from the date of mailing of this Final Decision and Order. The cover letter accompanying this final decision and order indicates the date the decision is mailed. Any petition for judicial review shall be made as provided for in the Administrative Procedure Act, Md. Code Ann., State Gov't § 10-222 and Title 7, Chapter 200 of the Maryland Rules of Procedure.

If Dr. Nelson files a petition for judicial review, the Board is a party and should be served with the court's process at the following address:

Maryland State Board of Physicians
Christine A. Farrelly, Executive Director
4201 Patterson Avenue
Baltimore, Maryland 21215

Notice of any petition should also be sent to the Board's counsel at the following address:

David S. Finkler
Assistant Attorney General
Department of Health and Mental Hygiene
300 West Preston Street, Suite 302
Baltimore, Maryland 21201